(1) Accommodation service charges for each newborn claim are the sum of nursery and neonatal intensive care unit charges divided by the number of newborns. Accommodation service charges for the mother are all other accommodation service charges.

(2) Ancillary charges for each claim are calculated by multiplying each ancillary charge by each claim's ratio of accommodation service charges in subitem (1) to the total accommodation service charges in subitem (1).

(3) If the newborn's inpatient days continue beyond the discharge of the mother, the claim of the newborn shall be combined with any immediate subsequent claim of the newborn.

(4) If the newborn does not have charges under subitem (1), the ancillary charges of the mother and newborn shall be separated by the percentage of the total ancillary charges that are assigned to all other mothers and newborns.

D. Combine claims into the admission that generated the claim according to readmissions at §12.4.

E. Determine operating costs for each hospital admission using each hospital's base year data according to subitems (1) to (6).

(1) Determine the operating cost of accommodation services by multiplying the number of accommodation service inpatient days by that accommodation service operating cost per diem and add the products of all accommodation services.

(2) Determine the operating cost of each ancillary service by multiplying the ancillary charges by that ancillary operating cost to charge ratio and add the products of all ancillary services.

(3) Determine the operating cost of services rendered by interns and residents not in an approved teaching program by multiplying the number of accommodation service inpatient days in subitem (1) by that teaching program accommodation service per diem and add the products of all teaching program accommodation services.

(4) Determine the cost of malpractice insurance, if that cost is not included in the accommodation and ancillary cost, by multiplying the total hospital costs of malpractice insurance by the ratio of the claim charge to total hospital charges and then multiply that product by 0.915.

(5) Add subitems (1) to (4) to determine the operating cost for each admission.

(6) Multiply the result of subitem (5) by the hospital cost index at §7.0 that corresponds to the hospital's fiscal year end.

F. Assign each admission and operating cost identified in item E, subitem (6), to the appropriate program or specialty group and diagnostic category.

G. Determine the mean cost per admission for all admissions identified in item F within each program and specialty group by dividing the sum of the operating costs by the total number of admissions.

H. Determine the mean cost per admission for each diagnostic category identified in item F within each program and specialty group by dividing the sum of the operating costs in each diagnostic category by the total number of admissions in each diagnostic category.

I. Determine the relative value for each diagnostic category by dividing item H by the corresponding result of item G within the program and specialty group and round the quotient to five decimal places.

J. Determine the mean length of stay for each diagnostic category identified in item F by dividing the total number of inpatient service days in each diagnostic category by the total number of admissions in that diagnostic category and round the quotient to two decimal places.

K. Determine the day outlier trim point for each diagnostic category and round to whole days.

5.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER ADMISSION AND PER DAY OUTLIER

5.01 Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per admission for each hospital according to items A to D.

A. Determine and classify the operating cost for each admission according to §4.01, items A to F, except that the ratios in item E, subitem (2) will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected.

B. Determine the operating costs for day outliers for each admission in item A that is recognized in outlier payments. For each base year admission that is a day outlier, cut the operating cost of that admission at the trim point by multiplying the operating cost of that admission by the ratio of the admission's days of inpatient hospital services in excess of the trim point, divided by the admission's length of stay, and then multiply the cut operating cost by each hospital's elected outlier percentage or 70 percent if an election is not made. When neonate or burn diagnostic categories are used, the department shall substitute 90 percent for the 70 percent or elected percentage.

C. For each admission, subtract item B from item A, and for each hospital, add the results within each program and specialty group, and divide this amount by the number of admissions within each program and specialty group.

D. Adjust item C for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of admissions by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add together each of the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital admissions and round that quotient to five decimal places.

(4) Divide the cost per admission as determined in item C by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.02 Minnesota and local trade area hospitals. The Department determines the adjusted base year operating cost per day outlier for each hospital according to items A and B.

A. To determine the allowable operating cost per day that is recognized in outlier payments, add the amounts calculated in §5.01, item B and divide the total by the total number of days of inpatient hospital services in excess of the trim point.

B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.03 Out-of-area hospitals. The Department determines the adjusted base year operating cost per admission and per day outlier by program and specialty group according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

5.04 Minnesota MSA and local trade area hospitals that do not have Medical Assistance admissions or day outliers in the base year and MSA hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota. The Department determines the adjusted base year operating cost per admission or per day outlier by program and specialty group according to items A to C.

A. Multiply each adjusted base year cost per admission and day outlier in effect on the first day of a rate year for each Minnesota MSA and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

5.05 Non-MSA hospitals that do not have Medical Assistance admissions or day outliers in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier by program and specialty group for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §5.04.

5.06 Limitation on separate payment and outlier percentage. Hospitals that have rates established under §5.03 may not have certified registered nurse anesthetists services paid separately and hospitals that have rates established under §5.03, §5.04, or §5.05 may not elect an alternative outlier percentage.

6.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY

6.01 Neonatal transfers For Minnesota and local trade area hospitals, the Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit (NICU) according to subitems (1) to (3).

(1) Determine the operating cost per day for each diagnostic category as defined at §2.0, item D according to §4.01, items A to F, except that the ratios in item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

(2) Determine relative values for each diagnostic category at §2.0, item D, according to §4.01, items G, H, and I, after substituting the term "day" for "admission."

(3) Adjust the result of subitem (2) according to §5.01, subitem D, after substituting the term "day" for "admission."

6.02 Minnesota MSA and local trade area hospitals that do not have Medical Assistance neonatal transfer admissions in the base year. The Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU according to subitems (1) to (3).

(1) Multiply each adjusted base year cost per day in effect on the first day of a rate year for each Minnesota MSA and local trade area hospital by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

6.03 Non-MSA hospitals that do not have Medical Assistance neonatal transfer admissions in the base year. The Department determines the adjusted base year operating cost per day for admissions that result from a transfer to a NICU by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §6.02.

6.04 Long-term hospital. The Department determines the base year operating cost per day for hospital admissions to Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota as designated by Medicare for the rate year according to items A and B.

A. Determine the operating cost per day according to §4.01, items A to E, except that claims excluded in §4.01, item B, subitems (2) and (4), will be included and the ratios in §4.01, item E, subitem (2), will be adjusted to exclude certified registered nurse, anesthetist costs and charges if separate billing for these services is elected.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

6.05 Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota that do not have Medical Assistance admissions in the base year. The Department determines the operating cost per

day according to items A to C.

A. Multiply each operating cost per day in effect on the first day of a rate year for each Minnesota and local trade area long-term hospital by the number of corresponding days in that hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all long-term hospitals and round that amount to whole dollars.

7.0 DETERMINATION OF HOSPITAL COST INDEX (HCI)

7.01 Adoption of HCI. The most recent *Health Care Costs* published by Data Resources Incorporated (DRI) is used.

7.02 Determination of HCI. For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the Department determines the HCI according to items A to G.

A. The Department obtains from DRI the average annual historical and projected cost change estimates in a decimal format for the operating costs in subitems (1) to (7):

(1) Wages and salaries.

(2) Employee benefits.

(3) Medical and professional fees.

(4) Raw food.

(5) Utilities.

(6) Insurance including malpractice.

(7) Other operating costs.

B. Obtain data for operating costs of hospitals in Minnesota that indicate the proportion of operating costs attributable to item A, subitems (1) to (7).

C. For each category in item A, multiply the amount determined in item B by the applicable amount determined in item A.

D. Add the products determined in item C and limit this amount to the statutory maximums on the rate of increase. Round the result to three decimal places.

E. For the period beginning October 1, 1992, through June 30, 1993, add 0.01 to the index in item D.

F. Beginning with the 1997 rate year, the HCI from the prior rate year to the current rate year is the change in the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by DRI in the third quarter of that prior rate year to the current rate year.

G. The 2000 rate year HCI is reduced .025 for payments of inpatient hospital services provided in that year. The HCI before the .025 reduction will be used in the determination of the HCI for subsequent rate years.

H. Add one to the amounts calculated in items E and F and multiply these amounts together. Round the result to three decimal places.

8.0 DETERMINATION OF PROPERTY COST PER ADMISSION

8.01 Minnesota and local trade area hospitals. The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each hospital admission in §4.01, item D using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost to charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in §4.01, item D using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3) to the appropriate diagnostic category program and specialty group.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

8.02 Out-of-area hospitals. The Department determines the property cost per admission by program according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

8.03 Minnesota MSA and local trade area hospitals that do not have Medical Assistance admissions in the base year and MSA hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota. The Department determines the property cost per admission by program and specialty group according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area MSA hospital by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total admissions for all MSA hospitals and round the resulting amount to whole dollars.

8.04 Non-MSA hospitals that do not have Medical Assistance admissions in the base year. The Department determines the property cost per admission by program and specialty group by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §8.03.

9.0 DETERMINATION OF PROPERTY COST PER DAY

9.01 Neonatal transfers. For Minnesota and local trade area hospitals, the Department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a NICU according to §8.01, item D, after substituting the term "day" for "admission."

For Minnesota and local trade area hospitals that do not have Medical Assistance neonatal transfer admissions in the base year, the Department will determine the neonatal transfer property cost per day for admissions in the base year according to §8.03 after substituting the term "day" for "admission."

9.02 Long-term hospitals. For long-term hospitals, the Department determines the property cost per day for hospital admissions to Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota as designated by Medicare according to §9.01, except that claims excluded in §4.01, item B, subitems (2) and (4) will be included.

For Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota that do not have Medical Assistance admissions in the base year, the Department determines the property cost per day according to items A to C.

A. Multiply each property cost per day in effect on the first day of a rate year for each Minnesota and local trade area long-term hospital by the number of corresponding days in that long-term hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all the long-term hospitals, and round the resulting amount to whole dollars.

10.0 DETERMINATION OF RATE PER ADMISSION AND PER DAY

10.01 Rate per admission. The Department determines the rate per admission for Minnesota and local trade area hospitals as follows:

The payment rates are based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year HCI.

Rate Per Admission	=	[{(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission} and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment multiplied by core hospital adjustment] plus rebasing adjustment

10.02 Rate per day outlier. The day outlier rates are in addition to the rate per admission and will be determined by program or specialty group as follows:

A. The rate per day for day outliers is determined as follows:

Outlier Rate Per Day	=	{Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment multiplied by core hospital adjustment}

B. The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services.

10.03 Transfer rate. Except for admissions subject to §10.04, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

Transfer Rate = Rate Per Day {(The rate per admission in item A, below, divided by the arithmetic mean length of stay of the diagnostic category) plus rebasing adjustment}

A. A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission unless that admission is a day outlier.

B. Except as applicable under §12.4, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

10.04 Rate per day.

A. Admissions resulting from a transfer to a NICU and classified to a diagnostic category of §2.0, item D will have rates determined according to §10.01 after substituting the word "day" for "admission."

B. Admissions for patients that are not transfers under §10.04, item A and are equal to or greater than the age of one at the time of admission and are classified to diagnostic categories KK1 through NN3 of §2.0, items A and B with a length of stay less than 50 percent of the mean length of stay for its diagnostic category under §4.01, item J, will be paid according to §10.03.

C. Admissions or transfers to a long-term hospital as designated by Medicare for the rate year will have rates determined according to §10.01 after substituting the word "day" for "admission."

10.05 Neonatal respiratory distress syndrome. For admissions to be paid under diagnostic category KK5 of §2.0, items A and B, inpatient hospital services must be provided in either a level II or level III nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

11.0 RECAPTURE OF DEPRECIATION

11.01 Recapture of depreciation. The Department determines the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to Medical Assistance, using methods and principles consistent with those used by Medicare to determine and apportion the recapture of depreciation.

11.02 Payment of recapture of depreciation. A hospital shall pay the Department the recapture of depreciation within 60 days of written notification from the Department.

Interest charges must be assessed on the recapture of depreciation due the Department outstanding after the deadline. The annual interest rate charged must be the rate charged by the Department of Revenue for late payment of taxes in effect on the 61st day after the written notification.

12.0 PAYMENT PROCEDURES

12.1 Submittal of claims. Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.

12.2 Payment for readmissions. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:

(1) A recipient leaving the hospital of the first admission against medical advice;

(2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or

(3) A recipient having a new episode of an illness or condition.

B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:

(1) Hospital or physician scheduling conflict;

(2) Hospital or physician preference other than medical necessity;

(3) Patient preference; or

(4) Referral.

C. When a readmission occurs as a result of an inappropriate discharge from the first admission, the first admission will be denied payment and the readmission will be considered a separate admission.

13.0 DISPROPORTIONATE POPULATION ADJUSTMENT

13.01 Disproportionate population adjustment or DPA eligibility. A Minnesota or local trade area hospital that is not state-owned, that is not a facility of the federal Indian Health Service, and that meets the criteria of items A to D is eligible for an adjustment to the payment rate.

A. A hospital that offers obstetric services must have at least two obstetricians with staff privileges who have agreed to provide obstetric services to Medical Assistance recipients. For non-MSA hospitals the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. A hospital that did not offer non-emergency obstetric services as of December 21, 1987 or a hospital whose inpatients are predominately under 18 years of age is not subject to item A.

C. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds 1 percent.

D. A hospital must have a base year Medical Assistance inpatient utilization rate that exceeds the arithmetic mean for Minnesota and local trade area hospitals or a low-income inpatient utilization rate that exceeds .25, determined as follows:

Medical Assistance Inpatient Utilization Rate = Medical Assistance inpatient days divided by total inpatient days

If the hospital's Medical Assistance inpatient utilization rate is at the mean, the calculation is carried out to as many decimal places as required to show a difference.

Low Income Utilization Rate = [(Medical Assistance revenues and any cash subsidies received by the hospital directly from state and local government) divided by (total revenues, including the cash subsidies amount for patient hospital services)] plus [(inpatient charity care charges less the cash subsidies amount) divided by (total inpatient charges)]

For purposes of this section, "charity care" is care provided to individuals who have no source of payment from third party or personal resources.

13.02 Medical Assistance inpatient utilization DPA. If a hospital meets the criteria of §13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean in §13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient utilization rate.

B. Add 1.0 to the amount in item A.

C. If a hospital meets the criteria of §13.01, items A or B and the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in §13.01, item C, the payment adjustment determined under item A is multiplied by 1.1, and added to 1.0.

13.03 Low income inpatient utilization DPA. If a hospital meets the criteria of §13.01, items A or B and the low-income inpatient utilization rate under item C, the payment adjustment is determined as follows:

A. Subtract .25 from the hospital's low-income inpatient utilization rate.

B. Add 1.0 to item A if item A is positive.

13.04 Other DPA. If a hospital meets the criteria of §13.01, items A or B and both the Medical Assistance inpatient utilization rate criteria and the low-income inpatient utilization rate criteria, the DPA is determined as described in §13.02.

13.05 Rateable reduction to DPA. If federal financial participation is not available for all payments made under §§13.01 to 13.04, the payments made shall be rateably reduced a percentage sufficient to ensure that federal financial participation is available for those payments as follows:

A. Divide the federal DPA limit by the total DPA payments to determine an allowable DPA payment ratio.

B. Multiply the result of item A by each hospital's DPA under §13.02 or §13.03.

C. Add 1.0 to the amount in item B.

13.06 Additional DPA. A DPA will be paid to eligible hospitals in addition to any other DPA payment as calculated under §§13.01 to 13.04. A hospital is eligible for this additional payment if it had:

A. Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of 13 percent of total Medical Assistance fee-for-service payment volume. Hospitals meeting this criteria will be paid $1,515,000 each month beginning July 15, 1995.

B. A hospital is eligible for this additional payment if it had Medical Assistance fee-for-service payment volume during calendar year 1991 in excess of eight percent of total Medical Assistance fee-for-service payment volume and is affiliated with the University of Minnesota. A hospital meeting this criteria will be paid $505,000 each month beginning July 15, 1995.

14.0 APPEALS

A hospital may appeal a decision arising from the application of standards or methods of the payment system. An appeal can result in a change to the hospital's payment rate or payments. Both overpayments and underpayments that are discovered as a result of the submission of appeals will be implemented. Regardless of any appeal outcome, relative values shall not be recalculated.

The appeal will be heard by an administrative law judge according to Minnesota Statutes, chapter 14, or upon agreement by both parties, according to a modified appeals procedure established by the Department and the Office of Administrative Hearings. In any proceeding, the appealing party must demonstrate by a preponderance of the evidence that the Department's determination is incorrect or not according to law.

A. To appeal a payment rate or payment determination or a determination made from base year information, the hospital must file a written appeal request to the Department within 60 days of the date the payment rate determination was mailed to the hospital. The appeal request shall specify:

(1) The disputed items.

(2) The authority in federal or state statute or rule upon which the hospital relies for each disputed item.

(3) The name and address of the person to contact regarding the appeal.

B. To appeal a payment rate or payment change that results from a difference in case mix between the base year and the budget year, the procedures and requirements listed above apply. However, the appeal must be filed with the Department within 120 days after the end of the rate year. A case mix

appeal must apply to the cost of services to all Medical Assistance patients that received inpatient services from the hospital. For a case mix appeal filed after July 1, 1997, the combined difference in case mix for Medical Assistance and General Assistance Medical Care, a State-funded program, must exceed five percent. For this paragraph, "hospital" means a facility holding the provider number as an inpatient service facility.

C. To appeal a payment rate or payment change that results from Medicare adjustments of base year information, the 60-day appeal period begins on the mailing date of the notice by the Medicare program or the date the Medical Assistance payment rate determination notice is mailed, whichever is later.

D. As part of the appeals process, hospitals are allowed to seek changes that result from differences in the type of services provided or patient acuity from the base year. This is necessary because of the time lag between the base year and the rate year. These case mix appeals are calculated after the rate year has finished. However, in a few situations such as the creation of a new program, it is prospectively evident that a case mix appeal will be successful. Therefore, in these cases, an agreement is drafted mandating a case mix appeal calculation at the end of the year and estimated payments are made on an interim basis.

15.0 OTHER PAYMENT FACTORS

15.01 Charge limitation. Individual hospital payments, excluding DPA payments, established for Medical Assistance covered inpatient services in addition to third party liability for discharges occurring in a rate year will not exceed, in aggregate, the charges for Medical Assistance covered inpatient services paid for the same period of time to a hospital.

15.02 Indian Health Service. Medical assistance payments to facilities of the Indian Health Service and facilities operated by a tribe or tribal organization under funding authorized by title III of the Indian Self-Determination and Education Assistance Act, Public Law Number 93-638, or by United States Code, title 25, chapter 14, subchapter II, sections 450f to 450n, are excluded from the DRG system and are paid according to the rate published by the United States assistant secretary for health under authority of United States Code, title 42, sections 248A and 248B.

15.03 Small rural payment adjustment. Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds on March 1, 1988, and 100 or fewer Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 20 percent.

Effective for admissions occurring on or after October 1, 1992, Minnesota hospitals with 100 or fewer licensed beds and greater than 100 but fewer than 250 Minnesota Medical Assistance annualized admissions paid by March 1, 1988 for the period of January 1, 1987 through June 30, 1987, will have payments increased by 15 percent.

The payment adjustment does not include Medicare crossover admissions in the admissions count nor are Medicare crossover admissions eligible for the percentage increase. Minnesota hospitals located in a city of the first class are not eligible for the payment adjustment.

The small rural payment adjustment is reduced by the amount of the hospital's DPA under §§13.01 to 13.05 and the hospital payment adjustment under §15.05.

15.04 Hospital payment adjustment. If federal financial participation is not available for all payments made under §§13.01 to 13.04 and payments are made under §13.05 or if a hospital does not meet the criteria of §13.01, items A or B, and the Medical Assistance inpatient utilization rate exceeds the mean in §13.01, item C, a payment adjustment is determined as follows:

A. Subtract the mean for Minnesota and local trade area hospitals from the hospital's Medical Assistance inpatient rate.

B. Add 1.0 to the amount in item A.

C. If the Medical Assistance inpatient utilization rate exceeds the mean plus one standard deviation in §13.01, item C, the payment adjustment determined in item A is multiplied by 1.1 and added to 1.0.

D. Payment adjustments under this section are reduced by the amount of any payment received under §§13.01 to 13.04.

Payments made under this section are not disproportionate share hospital payment adjustments under §1923 of the Social Security Act.

15.05 Core hospital adjustment. Medical Assistance inpatient rates will increase as follows for admissions occurring July 1, 1993 to June 30, 1995:

A. For admissions to a children's hospital, increase nine percent. A children's hospital is an acute care facility engaged in furnishing services to inpatients who are predominantly individuals under 18 years of age.

B. For admissions to a public hospital with calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume in excess of 13 percent of total calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume, increase six percent.

C. For admissions to a teaching hospital operated by the University of Minnesota and having calendar year 1991 fee-for-service Medical Assistance inpatient dollar volume in excess of eight percent of total calendar year 1991 fee-for-service Medical Assistance dollar volume, increase three percent.

15.06 Rebasing adjustment. Payment to Minnesota and local trade area hospitals for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 include a rebasing adjustment that is designed to prospectively compensate for an effective date of July 1, 1992 under the rates and rules in effect on October 25, 1993.

A. The adjustment to each hospital is calculated as the difference between payments made under this State plan and what was paid under each State plan in effect from July 1, 1992 to October 24, 1993, excluding the indigent care payment, with the following adjustments.

(1) Rates under this State plan are deflated 5.4 percent to remove the 1993 HCI. Rates are not deflated when the admissions under adjustment occurred in 1993.

(2) The core hospital increase is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(3) The small rural payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (October 1, 1992).

(4) The hospital payment adjustment is included when the admissions under adjustment occurred under a State plan that included it (July 1, 1993).

(5) The DPA is calculated using base year data under this State plan and the formulas under the State plan in effect for the admissions under adjustment (changed October 1, 1992).

(6) The cash flow payment adjustment under all State plans from July 1, 1992 to October 24, 1993 is deducted from the payment for admissions under adjustment.

B. Aggregate amounts owed to the hospital under item A are reduced by twenty percent. Payments for the cash flow payment adjustment are subtracted. The net difference is divided by 1.5 times the number of admissions under adjustment after mother and baby admissions are separated to derive a per admission adjustment. A hospital with an aggregate amount owed to the Department that exceeds one million dollars and has a payment reduction due to rebasing that exceeds twenty percent will have the net difference divided by 3.0 times the number of admissions under adjustment.

C. The rebasing adjustment will be added to or subtracted from each payment for admissions excluding Medicare crossovers, occurring on or after October 25, 1993 until the aggregate amount due to or owed by a hospital is fully paid.

D. The rebasing adjustment will occur over two periods.

(1) The first adjustment for admissions occurring from July 1, 1992 to December 31, 1992 and paid by August 1, 1993 begins with admissions occurring on or after October 25, 1993.

(2) The second adjustment for admissions occurring from January 1, 1993 to October 24, 1993 and paid by February 1, 1994 begins the later of February 1, 1994 or after the first adjustment is fully paid.

15.07 Out of state negotiation. Out-of-area payments will be established based on a negotiated rate if a hospital shows that the automatic payment of the out-of-area hospital rate per admission is below the hospital's allowable cost of the services. A rate is not negotiated until the claim is received and allowable costs are determined. Payments, including third party liability, may not exceed the charges on a claim specific basis for inpatient hospital services that are covered by Medical Assistance.

15.08 Psychiatric services contracts. The Commissioner has determined that there is a need for access to additional inpatient hospital psychiatric beds for persons with serious and persistent mental illness who have been civilly committed or voluntarily hospitalized and can be treated and discharged within 45 days. In response, contracts with non-state operated hospitals to provide inpatient hospital psychiatric services to patients who will be dually committed to the non-state operated hospital and the State-operated regional treatment center, or who have agreed to hospitalization, have been established. Payment rates for these inpatient psychiatric services are negotiated and established in the contracts executed under an open bidding process between the Commissioner and the hospitals.

A. Parameters related to the acceptance of a proposal other than cost include:

(1) the quality of the utilization review plan;

(2) experience with mental health diagnoses; and

(3) the commitment process.

B. Parameters related to acceptance of a proposal on a financial and cost basis include:

(1) payor of last resort/payment in full compliance assurances;

(2) general experience operating within the Medicare/Medical Assistance programs; and

(3) financial integrity.

C. Voluntary hospitalizations are included in the contracts under the following conditions:

(1) the Department and county must give prior approval;

(2) the hospitalization must be an alternative to commitment;

(3) the patient must have a past history of psychiatric hospitalization requiring extended inpatient psychiatric treatment; and

(4) the county would seek commitment if the patient did not agree to hospitalization.

Rates are established through the bid process with negotiation based on the cost of operating the hospital's mental health unit as derived from the Medicare cost report. The cost information, for comparison to a state-operated hospital, is adjusted to take into account average acuity and length of stay differences.

15.09 Medical education. In addition to Medical Assistance payments included in this Attachment, Medical Assistance provides for an additional one-time payment for medical education for Federal Fiscal Year 2001 (October 1, 2000 through September 30, 2001) to the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in State Fiscal Year 1996. The Medical Assistance payment for each of these six hospitals is increased as follows:

One-time Dollar Amount	x	(Total State Fiscal Year 1996 Medical Assistance admissions for one of the six Minnesota Medical-Assistance enrolled teaching hospitals) ÷ (Total State Fiscal Year 1996 Medical Assistance admissions of the six Minnesota Medical Assistance-enrolled teaching hospitals with the highest number of Medical Assistance admissions in that fiscal year)

The one-time Medical Assistance payment for Federal Fiscal Year 2001 is $27,125,108.41. In accordance with Code of Federal Regulations, title 42, section 447.253(b)(2), in no event shall this payment exceed the Medicare upper payment and charge limits as specified in Code of Federal Regulations, title 42, section 447.272.

15.10 Additional adjustment for Hennepin County Medical Center and Regions Hospital. Beginning July 15, 2001, in recognition of the services provided by the two largest safety net hospitals, an additional adjustment will be made each month to:

(1) Hennepin County Medical Center in the amount of $2,840,000.

(2) Regions Hospital in the amount of $1,420,000.